DOCUMENT RESUME

ED 199 960 EC 132 450

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TITLE Approaches to Children in the Mainstreaming Process: A Psychological and Administrative Perspective.
PUB DATE 80
NOTE 11p.; Paper presented at the Annual Meeting of the National Association of School Psychologists (13th, Washington, DC, April 19, 1980). Print may be marginal in parts.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavior Change; *Disabilities; Institutions; *Mainstreaming; Peer Acceptance; *Psychologists; Role Perception; *Student Evaluation

ABSTRACT

The changing role of the psychologist in an institution for handicapped children is discussed. Adaptation of tests, selection of instruments, and the importance of interview techniques are considered in a section on assessment. Programing aspects, including dealing with stereotyping behaviors and self abuse and helping teachers locate resources, are examined. The psychologist's role in enhancing the acceptance of handicapped children by their peers is also addressed. (CL)

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APPROACHES TO CHILDREN IN THE MAINSTREAMING PROCESS: A PSYCHOLOGICAL AND ADMINISTRATIVE PERSPECTIVE

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Paper presented at National Association of School Psychologists 12th Annual Convention
Capitol Hilton, Washington, D.C. April 9, 1980

EC132452

APPROACHES TO CHILDREN IN THE MAINSTREAMING
PROCESS: A PSYCHOLOGICAL AND ADMINISTRATIVE PERSPECTIVE

Traditionally, the role of the psychologist in the schools has been geared toward diagnosis and placement of children. Through a combination of testing, observational, and interview skills, the psychologist was a key figure in assisting the attending physician in the decision making process relative to a child's placement - whether or not to institutionalize.

Within the institution however, the psychologist was expected primarily, to provide estimates of current levels of functioning and to help develop maintainance programs for continued "institutional living." Until recently, the institutional psychologist had as his/her goal, the continuation of that placement, with little emphasis placed upon movement away from the residential setting. This role definition, however, underwent powerful changes as a result of legislation and court decisions in the areas of normalization and re-integration. As a result of extensive civil rights actions, large numbers of previously segregated retarded individuals were mandated to return to more "normalized" social settings. This had a significant effect upon the psychologist's role. Now the psychologist was being asked to provide community living skills as opposed to institutional living skills, and "current functioning" took on new importance in terms of its ability to predict readiness for community life. The development of programs designed to teach more sophisticated, socially appropriate skills became crucial, rapidly overtaking diagnostics as a needed area of competence for the psychologist. Psychodiagnostics, psychometrics and counselling, are now joined by behavior modification, multidisciplinary teams and integrated university affiliated programs as major components of the psychologist's life.

The institutional psychologist can no longer be expected to function autonomously in an isolated setting, but rather, must now mesh his skills with professionals in the community, carefully planning programs that can be carried over

when the child reaches the schools. Likewise, the psychologist in the schools, must become familiar with a more handicapped population than had previously been serviced in the public schools, as well as gaining an awareness of associated problems and methods of treatment. This may also require the learning, sharpening or broadening of assessment skills to include facility with tests not frequently found within the repertoire of traditional psychological batteries.

ASSESSMENTS:

The institutional psychologist has usually found it helpful to be somewhat creative and flexible in assessing the handicapped individual. Most of the standardized tools given to non-handicapped youngsters cannot be given in their entirety to a handicapped child. Parts of tests are often given in combination with selected parts of others, and time limits must often be more gracious that the test manual indicates. This results in a more frequent use of "testing of the limits," with appropriate explanations and descriptions offered within the psychologist's report. Because children with physical impairments will frequently require more time to complete a task, it is important for the psychologist to allow this extra time in order to avoid frustrating the child who is eager to complete the given items. This will also cue the examiner to the child's strengths and weaknesses, or "capabilities and needs," terms more commonly used in the New York State system of developmental disabilities. The psycholcgist will need to consider the child's individual abilities and handicaps before choosing any assessment tools. The Stanford-Binet and Wechsler scales are often substituted with tests more appropriate to the child's functional level, frequently suggesting the use of infant scales, (Merrill Palmer, Cattell, Kaufman Developmental) behavior scales, (AAMD Adaptive Behavior Scale, PPAC - Progress Assessment Chart) or specific others oriented toward specific handicaps. The Hayes-Binet is a version of the Stanford-Binet for a blind population, whereas the Leiter International Performance Scale has gained popularity for use with non-verbal, non-English speaking or deaf children. Picture vocabulary tests such as the

Peabody (and lesser known ones such as the Van Alstyne) can be adapted for use with both non-hearing individuals able to lip read or sign, as well as for children with Cerebral Palsy, since little fine motor dexterity other than pointing is required. Oftentimes the examiner may restructure the situations by pointing to each of the alternatives, encouraging the child to nod his head, blink, (or whatever response he can show with relative ease) to indicate the answer of his choice. For practical benefit in assisting the multiply handicapped child, it may be worthwhile for the psychologist to learn sign language or total communication.

Caution should be exercised against using test materials with tiny parts, as the immature child may tend to mouth them. It is also a good idea to use picture cards with waxed surfaces for easy cleaning. If edible reinforcements are to be used, it is suggested that the examiner first consult the parent or primary caretaker to determine whether the child is on a special diet. Many severely handicapped children have accompanying medical problems which might limit their sugar intake, or restrict the size of the particles they can comfortably chew and swallow. There are a variety of other tests which the psychologist in the institution has come to rely upon. (S)he will not discard any instrument with potential value, even if it is not chronologically age appropriate according to the instruction manual. It is necessary for the examiner to administer assessment tools that tap the child's functional level, regardless of the population upon which it was standardized. This thrust toward revealing areas of practical skill aquisition as well as those where improvement is needed, has encouraged the practice of prescriptive testing, for identification of goals to be included within the overall daily program or curriculum. This search for capabilities and needs has resulted in a de-emphasis of I.Q. scores and the dwindling use of projective techniques within the institution. There is little realistic need for full test batteries, as it is often nearly impossible to delve into emotional areas with a client whose sensori-motor handicaps

may render him unable to communicate adequately, or with a child who operates on a very concrete level, unable to verbalize any fantasy life. Traditional tests such as the T.A.T., Rorschach, Sentence Completion and figure drawings are used infrequently, if at all, as they are usually not applicable.

When observation and assessment alone have not given the psychologist the answers (s)he needs to develop a program, interview techniques may supply a great deal of additional information. The Vineland Social Maturity Scale for educable children and the AAMD Adaptive Behavior Scale for the more handicapped, are staples for the psychologist analyzing the behavior of mentally retarded persons. Both scales require a third party (informant) who knows the child well, to furnish information to the recorder (psychologist). Questions tap social and functional areas, with different scores given according to the development and frequency of occurance of a particular skill. While its primary benefit is a qualitative profile of the child's behavioral repertoire, these scales also yield a global figure, indicative of the child's overall social development. Analysis of the scatter in skill acquisition can be an important guide to the teacher developing an IEP.

PROGRAMMING:

Following the diagnostic assessment and identification of functional levels, the psychologist would set up a curriculum or program, to focus on the skills in need of development. Within the institution, the principle focus of skill attainment was related to the meeting of custodial needs, which in turn alleviated some of the burden placed on overworked care givers. Children had few expectations for accomplishment placed upon them, but they learned to respond to the simplest of commands and to finger feed themselves, seemingly the fundamentals for institutional survival. Sinces wards were overcrowded, dirty, noisy and understaffed, children received very little recognition, and only the most basic needs were met. The approach frequently taken was a homogeneous one, where everybody received similar medications, clothing and food, in a systematic, impartial, and impersonal way. There was no

opportunity to afford any child individual care. Therapeutic programming was absent, and self help skills and toilet training were remarkably delayed, if ever acquired at all. Children who spent most of their lives in such a setting, frequently began to adopt strange behaviors. Finger flicking, hand waving, twirling, playing with string and rocking were such commonly observed behaviors that they came to be known as stereotypic. Little was done to replace these behaviors with more productive ones. Widely accepted hypotheses attribute the generation of these behaviors to the seeking of attention from the elusive and ever busy attendant, as well as the seeking of some stimulation not provided by the environment.

Self abuse was also prevalent and recognized as the consequence of attempts to change an unresponsive environment. Head banging, face slapping, digging/gouging, and biting proved to be an effective way of causing commotion and guaranteeing that somebody would rush to the child's side, if even for just the moment required to administer the necessary medical treatment. The price paid in terms of personal injury was probably meager, compared with the rewards reaped by the contact-hungry child. Of course, not all self-injurous behavior is a means of communication. For example, Lesch-Nyhan Syndrome, a ferocious form of self mutliation, is X-linked recessive, and produces several other physical complications. However, the teacher receiving a self-injurious child whose behavior has been learned in order to gratify his needs, is one who will need to redirect the child's attempts at gaining attention.

Dealing with self-abusive behaviors, while significant, must now also be coordinated with the refinement of behaviors needed by the child when (s)he goes into the community. The socially accepted method of performing all skills becomes paramount. Manners are introduced, family style eating replaces finger feeding, clothing is personally selected by the individual and is reflective of current styles, toilet training becomes a priority, cleanliness is valued and communication skills are enhanced. The drive for normalization becomes all encompassing. The teacher may find that (s)he is no longer asked to teach academic fundamentals, but

rather to focus on skills needed to improve personal hygiene and self esteem. In this process the teacher is also laying the foundation for the exploration of the child's feelings, as they relate to acceptance/rejection by schoolmates. As the teacher's role undergoes change, the psychologist may be needed to help in locating needed resources as well as offering supports, during this critical time of charting new ground.

In addition to teacher preparation, acceptance of handicapped children by their non-handicapped classmates is a necessary element in successful mainstreaming. However, peer reception of deinstitutionalized clients represents an area of study which has received relatively little attention in the literature. Emphasis instead, has been placed on diagnosis, selection criteria, professional training, curriculum, administrative structures and multidisciplinary support teams. Whatever the variable however, the goal of de-institutionalization is to place the child in a least restrictive environment, a place where (s)he can engage in normal patterns of social interaction with his or her non-handicapped peers. It is the belief of the mainstreaming philosophy that admission into a normal social system will better provide the client with the skills necessary for independent or minimally dependent living. This is in opposition to the total dependency created by the institution. Living within a community is seen as providing the child with a better life situation, greater opportunity to reach potential, and a less stigmatized and prejudiced existence. It is apparent that the success of mainstreaming would be primarily dependent on the acceptance of the handicapped individual by those with whom we expect him to interact. It must be remembered however, that the child's initial placement in the institution was often the result of his inability to function within normal social patterns, and the inability of his peers and significant caretakers to accept him. Reversing this process would require at least a two-step program; 1) training the client so that he can perform in socially appropriate ways, and 2) preparing the social system to receive the newly returning handicapped child.

Issues relative to client training, while significant, are beyond the scope of this presentation. Instead, this paper will emphasize those variables pertinent to an understanding of peer and teacher interactions within the mainstreaming situation. In placing the de-institutionalized child into a public school setting, it is necessary to prepare all those who come in contact with the child, for his introduction into the system. This might include teachers, principals, pupil personnel staff, secretaries, aides, para-professionals, parents and non-handicapped peers. The remainder of this paper, however, will specifically address techniques for preparing non-handicapped peers.

It is likely that interactions with other children will comprise the major portions of the higher functioning handicapped child's social existence during the school day. It would seem obvious that the success or failure of these peer interactions will have a direct influence on whether or not the total mainstreaming program will have a positive consequence. To help ensure this consequence, it is necessary that peers be sensitized to the appearance, behavior and needs of the handicapped child. There is little doubt that first contact with a seriously disabled person is an upsetting, painful, and awkward event, often evoking feelings of pity, curiosity, fear and anxiety. These feelings and the attitudes they engender often create a long lasting impression on the child, setting the tone for all later interactions with handicapped individuals.

Providing children with the emotional and cognitive apparatus necessary for dealing with these feelings on both a short and long term basis, represents a major task for the school psychologist. Preparing children for the concept of "handicapped" can proceed along a number of different paths, all of which have in common the premise that feelings and attitudes should be dealt with in a gradual "hands on" fashion. Its not enough to think about "handicapping" or deal with it conceptually. The child must be physically introduced to a handicapped

person if his attitudes, expectations and behavior are going to be effected. Classroom discussions, research on the lives of prominent handicapped individuals, film presentations, puppet shows, classroom visits to institutions, simulation exercises, role playing games, and visits by handicapped persons represent but a few of the possible techniques that the school psychologist can share with the classroom teacher. Following contact, it is important that the children be allowed to express themselves, sharing their feelings and experiences with their peers in a supervised setting. The school psychologist and/or teacher should moderate these discussions so as to aid the children in developing greater understanding and acceptance of their emotional reactions. Children must recognize that their anxieties and fears are common, and that exploring these feelings may help them to become more comfortable with, and accepting of other people. In order for the teacher to become a successful moderator, it is necessary that she, too, come to terms with her own feelings toward the handicapped.

At all times, it must be remembered that social systems require preparation prior to change. Following this preparation period, the non-handicapped child will be introduced to the actual experience of working with a handicapped youngster on a long term basis. Throughout these periods, feelings and attitudes previously described will continue to exert themselves on the patterns of interaction within the classroom. Once again, psychologist and teacher must be prepared to deal with and facilitate the development of acceptable social experience by creating an environment which necessitates the involvement of all students in some form of group activity. The tendency of social networks to exclude deviance and repel newcomers must be faced squarely. This may require that the teacher initially ally herself with the handicapped child, in opposition to peer pressures. Group discussions, peer tutoring, development of class-wide projects, etc., are but some of the ways that school personnel can help children learn to accomodate and accept the newly admitted handicapped child. At all times, the issues of feelings and attitudes must be recognized; to allow them to develop in an unsupervised manner might possibly

lead to their distortion and often times cruel expression. This is not to imply that the handicapped youngster should be totally protected from the feelings of his peers, but only that these feelings should be kept in perspective, and not permitted the exaggeration which so often accompanies attitudes toward the handicapped.

In a similar vein, the feelings of the handicapped child should also be approached in a gradual and consistent fashion. As part of a reciprocal social system, his feelings and the feelings he generates in others must be reviewed. Questions of inadequacy, impotence, rage, self-pity and separateness need examination. Advance preparation and continued participation both prior to, and during the adjustment phase must be made available.

Too often in a desire to be expedient, professionals move children too quickly, failing to adequately anticipate the emotional upheavals that accompany environmental change. Both the mainstreamed child and his new found peers will probably be resistant to change. Professionals must be sensitive to this resistance and develop techniques for minimizing its effect. Social integration can only be achieved through patience, consistency and sensitivity on the part of those who are responsible. It is not enough to evaluate mainstreaming exclusively in terms of the client. A social systems approach which includes all those involved in the process must be emphasized. For the school psychologist then, the client becomes a system, not an individual.